

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services**

**Notice of Intent to Possess and Use
Epinephrine Auto Injector**

Name of Entity	Agency Code #	Business Phone () -
Mailing Address	State:	Fax No. () -
City :		
Zip:		
Primary County of Operation:		

Type:	Ambulance Service	ALSFR Service	Overnight Camp	Summer Day Camp
	Traveling Summer Day Camp	Other _____		

If a camp check all that apply:	Camp Premises or Infirmary	Off-Site Trips/Events
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Name of Emergency Health Care Provider (MD or Hospital)	Business Phone No. () -
If a Hospital Provide Name of Contact:	Fax No. () -
Address	
City:	State: Zip:

Number of Trained Providers to Use Auto Injector in EMS service or camp:
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Minimum Number of Injectors to be Maintained On-Site: _____
Maximum Number of Injectors to be Maintained On-Site: _____

Authorizations:

Print Name of Service CEO or Camp Director	Date	Print EHC Provider (name)	Date
Signature		Signature	

Send this form and your Collaborative Agreement to the Regional EMS Council listed in the attachment.